Investigating Child Abuse and Neglect in Child Care Facilities Task Force

Report on Task Force Recommendations

February 27, 2004

NC Department of Health and Human Services
Secretary Carmen Hooker Odom, co-chair
The Honorable Janice McKenzie Cole, co-chair

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Background

In March 2001, House Bill 456, *Child Abuse and Neglect in Child Care Facilities Study,* was introduced in the NC General Assembly. This agency bill was the Division of Child Development's (DCD) effort to address issues related to abuse and neglect in child care centers and homes. HB 456 proposed a Study Commission to consider:

- Strengthening the protocol for handling child fatalities in child care facilities;
- Improving the coordination, effectiveness and timeliness of completion of child abuse and neglect investigations and actions taken at the local level among multiple agencies;
- Developing a more effective way to address illegal child care providers;
- Developing a system to track a person who is a substantiated child abuser or neglector who has been terminated by one child care facility so that they are not rehired by another facility; and
- Developing a system to permanently remove individuals from child care for substantiations of abuse and neglect.

HB 456 was included in the 2001-2002 General Assembly Studies Bill (S.L. 2001-491) but the Study Commission was never funded by the General Assembly.

In 2003, the Raleigh *News and Observer* published a series of articles about 33 child deaths that occurred in North Carolina child care facilities over four years. The articles drew attention to the occurrence of Sudden Infant Death Syndrome (SIDS) deaths in child care; identified risks and problems associated with illegal child care; and examined the investigation process of agencies when deaths occur in child care. The articles raised public awareness about the safety of child care and urged legislative and procedural changes to better protect children.

Carmen Hooker Odom, the Secretary of the North Carolina Department of Health and Human Services, subsequently convened a group of stakeholders to consider ways to strengthen child care services provided to North Carolina's children. The group consisted of partners from the medical community, the North Carolina Child Care Commission, local departments of social services, law enforcement, child advocates, state agencies, child care providers, state legislators and parents (see Appendix A). Much of the work of the *Investigating Child Abuse and Neglect in Child Care Facilities Task Force* (Task Force) focused on how to improve the system of investigating child abuse and neglect in child care facilities. The Task Force was co-chaired by Secretary Hooker Odom and Judge Janice McKenzie Cole.

The current process of investigating reports of child abuse and neglect in child care settings is a collaborative effort between the Division of Child Development (DCD) and county departments of social services. The Division is authorized to investigate reports of alleged abuse and neglect

in child care facilities to determine whether violations of child care requirements occurred. County departments of social services are mandated to investigate reports of alleged child abuse and neglect to determine whether a child is in need of protective services necessary to ensure his safety. Once a county department of social services completes its investigation and issues its findings (i.e., whether the report was substantiated or not) the Division of Child Development (DCD) may sanction the child care program through various administrative actions.

The Task Force met three times (May 2003, July 2003, and January 2004). As the work of the Task Force progressed, members of the North Carolina General Assembly worked to pass legislation related to several of the issues considered by the Task Force. Bills were passed in the 2003 Session that made it a felony to knowingly operate an illegal child care facility (S.L. 2003-192), required children to be placed on their backs to sleep in child care (S.L. 2003-407), established criminal penalties for the unauthorized administration of medicine to children in child care (S.L. 2003-406), and required providers to better inform parents of child care requirements and how to obtain records (S.L. 2003-196).

The Task Force identified several questions, which when answered, would help determine recommendations for improving the abuse/neglect investigation process in child care. Four groups were established to work on the questions: Child Neglect in Child Care Facilities, Child Physical and Sexual Abuse in Child Care Facilities, Child Fatalities in Child Care Facilities, and a statewide Parent Feedback work group. Work groups included members from the full Task Force and content experts from local departments of social services and the Divisions of Social Services (DSS) and Child Development (see Appendix B). Work groups met between the three full Task Force meetings to research the questions in their assigned areas, and were charged with reporting their findings to the full Task Force.

The Task Force recommendations to Secretary Hooker Odom were finalized at its January 2004 meeting. The work of the Task Force has strengthened the collaboration between the Divisions of Social Services and Child Development. Both agencies are committed to continuing to seek out ways to reduce abuse and neglect in child care, and to improve the investigation of reports of child abuse and neglect in child care facilities.

Task Force Recommendations

The four Task Force Work Groups met 18 times collectively, studied and researched 12 questions identified by the Task Force, and developed initial recommendations for consideration by the full Task Force. Four of their initial recommendations were very similar. They included:

- Developing a public awareness campaign;
- Notifying parents of administrative actions that change the status of a license and of substantiated cases of abuse and neglect;
- Creating a database that would track abuse and neglect perpetrators; and
- Convening an independent study group to look at how investigating complaints of abuse and neglect in child care centers and homes can be streamlined and made more effective and efficient.

The Task Force adopted the work groups' initial recommendations in its final set of recommendations, detailed below. All recommendations were considered to be equally important by the Task Force. Each recommendation includes a rationale statement and where appropriate, what efforts are already underway ("Current Progress") related to the recommendation.

1. A parental advocate/ombudsman position should be created to serve as liaison between the parents of a suspected abuse and neglect victim in child care and the various state agencies/divisions to help parents negotiate the complex system of government.

   Rationale: Parents of children who are victims of abuse or neglect in child care would have one source through which complex systems of information regarding investigations, etc., could be channeled.

   Current Progress: The NC Office of Citizen Services offers services to residents across the state that includes putting families in contact with appropriate agencies for information and help with the families' particular needs.

2. Develop a campaign that provides children's caregivers with "best practices" for effectively communicating with parents.

   Rationale: Information would be provided to parents that would help them make appropriate child care choices, and caregivers would obtain skills that would enable them to better communicate with parents.

3. Child care operators should be required to undergo training prior to opening a facility. Teachers should be required to undergo training prior to taking responsibility for children.

   Rationale: Prior training requirements would increase the safety of children in child care settings and teach caregivers how to appropriately report colleagues who are abusive and neglectful.

4. Improved sharing of information with the public by:
   a. Posting applicable staff/child ratios in each classroom facility.

   b. Developing a one-page document with information regarding the reporting of child abuse or neglect. The document could be printed from the DCD website and used on other websites of partnering agencies such as the NC Partnership for Children and local Smart Start partnerships.
      - The document could be distributed by DCD at conferences, trainings and meetings;
      - Partners such as pediatricians, obstetricians/gynecologists, local health departments, faith partnerships, the NC Partnership for Children and local Smart Start partnerships, child care resource and referral agencies, public health agencies, Prevent Child Abuse, the Child Advocacy Institute and the Department of Public Instruction would also be contacted to distribute the document.

Rationale: There is a relationship between staff/child ratio and child maltreatment. There is confusion in the public about where to report child maltreatment that occurs in child care. Better information sharing would increase the knowledge and awareness of the general public/parents, and lead to increased safety of children in child care settings.

Current Progress: The summary of the child care law that is given to parents by the provider and posted in each facility includes details on how to get information on facilities and how to report abuse and neglect.

5. To ensure that all appropriate parents are consistently notified at the beginning of a child abuse and neglect investigation, the Division of Social Services (DSS) should develop a safety assessment (written, formalized instructions, as a guideline) specific to child care settings that is implemented consistently across the state.

   Rationale: Currently DSS does family safety assessments. Consistent instructions are needed for using an assessment across the state to determine if children are at immediate risk of harm in a child care setting so that the appropriate parents are notified.

6. To ensure that all parents in child care settings are notified of investigation findings,
   - Administrative actions that change the status of the license should be posted at the center when issued. Center directors should be mandated to post any written warnings and written reprimands issued by DCD.

   - Center directors should be mandated to distribute all administrative actions that include substantiated licensing and child abuse or neglect complaints and the resolutions of these complaints to the parent of each child in the facility. A record of parent signatures should be maintained showing who has been given a copy of the administrative action. (The Parent Feedback and Child Neglect Work Groups independently proposed this recommendation.)

   Rationale: This recommendation would help parents be better informed and provide information that would help them know how to best protect their children and make the best choice for child care.

   Current Progress: Child care rules currently require that administrative actions changing the status of the license be posted in the child care center or home. Administrative actions are also listed on the DCD website. Hard copies of administrative actions are provided by DCD to parents and to the public upon request.

   Providers are also required to give parents a summary of the child care law. Recent legislation requires providers to post information on how parents can obtain a copy of the child care facility's records.

   The Division of Child Development widely publicizes the availability of child care facility information on its website by distributing postcards and business cards for advertising the website to resource and referral agencies and other partners. DCD

currently has a public awareness campaign that makes information available to parents by maintaining a website and distributing brochures and posters to child care providers and local partners that help parents and providers recognize quality child care.

7. a. A database should be created to include perpetrators of substantiated abuse/neglect in child welfare cases. This includes the establishment of an appeals process for individuals prior to their names being placed in the database. Access to this database should be readily available to all state agencies and other service providers. The Division of Social Services (DSS) should maintain the database and provide technical support to its users. In addition, all social workers should have free and easy access to state criminal records. DCD should study and evaluate the process of obtaining access to state criminal records and other relevant databases. (The Child Physical and Sexual Abuse, Parent Feedback and Child Neglect Work Groups independently proposed this recommendation.)

   Rationale: This would reduce the number of repeat offenders (individuals against whom child abuse or neglect has been substantiated) working in child care centers and homes and would halt movement of these individuals between facilities and possibly causing further harm to other children. It would also reduce repeat situations of child abuse and neglect in a facility.

   Current Progress: The Department of Health and Human Services is preparing to submit this recommendation to the House Interim Committee on Child Abuse, Neglect, Foster Care and Adoption for legislative consideration.

   b. Allegations involving physical harm to children, for example, excessive physical discipline or the withholding of food, should be investigated and if indicated, substantiated as child physical abuse. Only those "acts of omission" which do not result in physical harm to a child should be substantiated as neglect.

   Rationale: When a child is physically injured, the incident should be investigated as a child abuse case and not as a neglect case because signs of physical harm can disappear in less time than is required to investigate a neglect case.

8. Determine an effective streamlined process for investigating child abuse and neglect in child care facilities by organizing an independent study to look at how investigations of child abuse and neglect in child care facilities are conducted and to determine the best use of resources and the highest level of quality for these investigations. (The Child Physical and Sexual Abuse and Child Neglect Work Groups independently proposed this recommendation.)

   Rationale: This recommendation would improve the consistency and timeliness of investigations and would reduce the level of intrusiveness, confusion and duplication of efforts at the local level. The study would look at ways to provide consistent training and to develop better collaboration between investigative agencies. (The workgroups that recommended this felt there is a need for mandated, consistent training and collaboration among the investigative agencies.) The independent study would determine if the current

DSS procedure for investigating child abuse and neglect in child care facilities, which was developed for use in family situations, is the best procedure for use in child care settings.

9. The Medical Examiner's Office is currently working on a protocol for crime and death scene investigations. This protocol should be mandated to be used and should become part of the required training for all agencies involved. Associations and organizations should be identified to help ensure buy-in and the passage of the protocol within the NC General Assembly.

   Rationale: This protocol is needed to standardize and provide consistency in the level of investigations among all agencies across the state.

10. Toxicology testing should be conducted in all unexplained child deaths, specifically, children who die in child care facilities.
    - A toxicology test should be conducted before any case can be ruled as SIDS.
    - A thorough case investigation should be included as part of the SIDS definition.
    - The definition for SIDS should be: the diagnosis given for the sudden death of an infant under one year of age that remains unexplained after a thorough case investigation, including an autopsy, a death scene investigation, review of the infant's health status prior to dying, and other family medical history. (Definition Source: Centers for Disease Control and Prevention – US Department of Health and Human Services.) This definition should be adopted and used statewide for all local and state agencies.

    Rationale: Toxicology testing is needed to assist in ruling out SIDS and to determine a more accurate cause of death.

11. It should be prohibited for infants to be unsupervised during "sleep time" in family child care homes. (It was acknowledged that it would be difficult for home providers to comply with this policy.)

    Rationale: This policy is recommended to help ensure better supervision of children and to reduce the risk of SIDS.

12. a. An on-going public awareness campaign should be developed in order to educate every aspect of the general public using all available media and strategies on ways to prevent child fatalities, including those in child care facilities, and to educate parents on:
    - available child care resources;
    - how to obtain information on the history of a child care facility; and
    - how child abuse and neglect is defined in statute and how to report suspected cases of abuse and neglect.

(The Parent Feedback and Child Fatalities Work Groups independently proposed this recommendation.)

Current Progress: The Department of Health and Human Services' Public Information Office (PIO) posts to the web and releases monthly, a listing of substantiated actions taken against child care centers and homes. PIO also issues news releases when substantial actions (actions that change the status of the license) are taken against a child care center or home.

b. Establish an advisory committee group to help develop the campaign and plan activities.

Rationale: These recommendations would help prevent child fatalities in child care facilities, and information provided to parents would help parents make appropriate child care choices.

13. Revise the statewide child sexual abuse protocol on conducting child care investigations in child care facilities to include the following:

- identified roles/responsibilities of each investigative agency (removing the mandate that SBI have original jurisdiction in child care facilities);
- a consistent intake process and screening of child abuse reports;
- criteria levels for each investigative agency;
- a process for evaluating the use of the protocol at the conclusion of each case; and
- an evaluation process by a designated agency for annual reviews and possible revision of the protocol.

Rationale: The current sexual abuse protocol is not appropriate for most of the types of sexual abuse cases reported in child care. There is inconsistent use of the sexual abuse protocol across the state and duplication of efforts among investigative agencies (cost and resources). The time for DCD and DSS to complete investigations for case closure was also cited as a reason for this recommendation, as well as the need for better collaboration between investigative agencies.

14. Comprehensive training plans should be developed.

a. All agencies that respond to child fatalities should receive training in issues related to abuse and neglect. Those agencies should include the following:

- First level responders: dispatchers;

- Second level responders: emergency medical services, police/sheriff departments, fire departments, medical first responders; and

- Third level responders: medical examiners, departments of social services, medical examiners, doctors, district attorneys and the Division of Child Development.

b. An advisory group should come together to identify the training bodies and outline the strategies for each group.

Rationale: Implementing this recommendation would enhance the recognition of child abuse and neglect and possibly reduce the number of child abuse and neglect incidents that lead to child fatalities within child care.

c. A training coordinator position should be established at DCD to:

- develop and implement a child abuse curriculum for DCD staff, child care operators, child care employees and CCR&R staff;

- develop and implement a pre-employment Child Care Training Certificate regarding issues related to child care, including child abuse and neglect;

- coordinate participation with DSS's welfare training program;

- develop a required child abuse/neglect prevention training curriculum for annual in-service requirements for child care professionals; and

- research and/or develop training for child care administrators in all facilities regarding the business aspect of child care, researching and hiring staff, supervision of staff, evaluation of staff and the child care program.

Rationale: This recommendation would provide a continuation of updated and appropriate education related to child care and child abuse and neglect in child care for owners, providers and families. It would assist prospective owners and providers with child care issues in an effort to prevent child abuse and neglect and to provide better quality child care. It would also eliminate gaps in training.

d. Multidisciplinary team training should be mandated for investigation agencies and resource agencies that are involved in child abuse investigations in child care facilities.

Rationale: This recommendation would provide a continuation of appropriate education related to child abuse/neglect investigations in child care for investigative agencies. It would provide consistent information for all investigative agencies, reduce duplication of training, and would access the consistent training already available. It would facilitate cooperation between investigative agencies, broaden the basis of support when administrative actions are taken at facilities, and increase the understanding of follow-up needed.

e. Funding should be expanded for T.E.A.C.H (Teacher Education and Compensation Helps) scholarships and salary incentives, Prevent Child abuse training, Child Care Subsidy for parents and other training across the state.

Rationale: This recommendation would broaden community support regarding child care, assist in educating the public about child care issues, improve morale for child care operators and providers, and financially assist families with child care.

Additional Task Force Recommendations

The following recommendations came from Task Force members who did not work with one of the work groups to develop the initial recommendations presented to the Task Force. Members were given an opportunity at the January 2004 meeting to identify and make these additional recommendations.

1. Training for all "first responders" should incorporate recognizing abuse and neglect with CPR training.

2. Abuse and neglect reports made by physicians must activate a combined investigation in the child's home and child care facility.

3. The safety assessment protocol should clearly set timeframes for notification of parents since in some situations, timeliness of notification is critical.

4. Staff/child ratios in center based care should be reduced at the one star level and infant/toddler ratios should be created for family child care homes.

5. The definition of "caretaker" should be reviewed to include all staff/employees or providers working with or supervising children. This is necessary to ensure that possible abuse or neglect is investigated by DSS.

6. The 10 hour "new employee orientation" of child care workers currently required should be increased to 16 hours; completion of orientation should be required prior to beginning work; and at a minimum, an employee must complete the orientation prior to being assigned to work alone in a classroom. Orientation topics should be revised and expanded and should establish a minimum amount of training hours per topic.

7. Operators and providers should be encouraged to establish "mentoring" programs for new employees as a "best practice." The mentoring program would pair a seasoned staff member who had at least three years' experience and who possessed the knowledge of early childhood practices in the classroom with new employees.

First Steps – Where do we begin?

The Task Force clearly articulated that their recommendations were equally important. To establish a starting point, members identified recommendations that could immediately be moved forward. Staff will identify venues already in place to determine if they can be coupled with other initiatives to expedite implementation (for example, the House Interim Committee on Child Abuse, Neglect, Foster Care and Adoption; the work of the Medical Examiner's Office to develop a protocol for crime and death scene investigations; and coordination of training recommendations coming out of work done by other Task Forces).

The following Task Force recommendations are beginning steps in the process of moving forward with implementation goals. The remaining recommendations will be reviewed by the Secretary for assignment to the appropriate commission, state division, study group or advocacy agency.

- Determine an effective streamlined process for investigating child abuse and neglect in child care facilities by organizing an independent study to look at how investigations of child abuse and neglect in child care facilities are conducted and determine the best use of resources and the highest level of quality for these investigations.

- Create a database to include perpetrators of substantiated abuse and neglect in child welfare cases. This includes the establishment of an appeals process for individuals prior to their names being place in the database. Access to this database should be readily available to all state agencies and other service providers.

- Develop comprehensive training plans including establishing a training coordinator position at the Division of Child Development to develop and implement a child abuse curriculum for DCD staff, child care operators, child care employees and child care resource and referral staff. In addition, develop and implement a pre-employment Child Care Training certificate regarding issues related to child care, including child abuse and neglect.

- The Medical Examiner's Office is currently working on a protocol for crime and death scene investigation. This protocol should be mandated to be used, and should become a part of the required training for all agencies involved.

Conclusion

The *Investigating Child Abuse and Neglect in Child Care Facilities* Task Force has provided the Division of Child Development and the Division Social Services and their partners – parents, legislators, local law enforcement, state agencies, justice, advocacy groups, non-profit agencies and the medical community – a venue for coming together to plan for ways to better serve families and children. The Task Force has been successful in identifying areas that can be strengthened, collaborating on strategies by which change can be implemented, and in renewing interagency commitment to collaboration and cooperation.

Appendix A
Task Force Membership

Name	Title
Odom, Carmen Hooker	Secretary, NC Department of Health and Human Services and Task Force Co-chair
McKenzie Cole, Janice	Judge and Task Force Co-chair
Alexander, Martha	NC House of Representatives
Ball, Peggy	Director, NC Division of Child Development
Barnhart, Jeffrey L.	NC House of Representatives
Beal, Pheon	Director, NC Division of Social Services
Beatty, Bryan E.	Secretary, Crime Control and Public Safety
Clary, Debbie	NC House of Representatives
Cooke, Lane	Task Force Meeting Facilitator, UNC-CH
Deitch, Al	Interim Director, Youth Advocacy and Involvement
Foster, Sharon Dr.	Pediatrician/NC Child Care Commission
Freedman, Janice	Executive Director, NC Healthy Start Foundation
Gaskell, Julia	Parent Representative
Graves, Terrie	Child Care Provider
Griffin, Nicki	Director, Franklin County Social Services
Herman-Giddens, Marcia Dr.	Adjunct Professor, UNC-CH Senior Fellow, NC Child Advocacy Institute
Hice, Mandy	Parent Representative
Hunnicutt, Betty	Child Care Provider
Jackson, Brenda	Director, Greene County Social Services
Jones, Tammy	Parent Representative
Jones-Wilson, Diana	Executive Director, Faith Partnerships
Kotch, Jonathan Dr.	Professor & Associate Chair, School of Public Health UNC-CH
Lazo-Chadderton, Mattye	Special Assistant, NC Senate Pro Tem Office
Maynor, Priscilla	Sr. Asst. to State Superintendent
Morey, Marcia H.	Judge
Nye, Edd	NC House of Representatives
Palombo, Frank	President, NC Association of Chiefs of Police
Ponder, Karen	Director, NC Partnership for Children
Purcell, Bill Dr.	NC Senate
Ramaswamy, Anand	Assistant District Attorney – Alamance County
Rascoe, Donna	Parent Representative/NC Child Care Commission
Rector, Beth	Chair, NC Child Care Commission
Reeves, Eric	NC Senate
Russell, Sue	Executive Director, Day Care Services Association
Ryan, Kevin Dr.	NC Division of Maternal and Child Health
Schweitzer, Michael	Assistant Secretary, Juvenile Justice
Smith, Jean Dr.	Wake County Child Medical Evaluation Program
Stanford, Martha A. Dr.	Director, NC Justice Academy
Sweat, George	Secretary, Juvenile Justice
Thomas, Melanie	Assistant Director, State Bureau of Investigation
Tise, Nick	Emergency Medical Services for Children
Tobin, Kathy	Parent Representative
Tolle-Whiteside, Jennifer	Executive Director, Prevent Child Abuse NC
Ware, Joan	Parent Representative
White-Hearn, Rose	Director, Child Victim Assistance Program

Appendix B

CHILD FATALITIES WORK GROUP

NAME	AGENCY
Starling, Lauri	North Carolina Association for the Education of Young Children
Mayhew, Lisa	Office of Chief Medical Examiner
Hunnicutt, Betty	Wonder Years Child Care & Learning Center
Atwater, Annette	Orange County Department of Social Services
Troop, Tony	North Carolina Division of Social Services
Hester, Marta	North Carolina Division of Child Development
Kenan, Jinx	North Carolina Division of Child Development
Matherly, Jennifer	North Carolina Division of Child Development
Tise, Nick, Chairperson	North Carolina Office of Emergency Medical Services
Freedman, Janice	North Carolina Healthy Start Foundation
Teague, Ila	North Carolina Division of Child Development
Ramaswamy, Anand	Alamance County District Attorney's Office
Fisher, Gerry, Facilitator	North Carolina Office of State Personnel
Avent-Farmer, bj	North Carolina Division of Child Development
Wiggins, John	North Carolina Justice Academy – Eastern Campus
Lynch, Steve	Alamance County District Attorney's Office

CHILD NEGLECT WORK GROUP

NAME	AGENCY
Atkins, Erin	Johnston County Department of Social Services
Boyette, Denise	Johnston County Department of Social Services
Bushnell, Mary	North Carolina Child Care Resource & Referral Network
Clark, Allison	First Presbyterian Church Child Development Center
Kotch, Jonathan Dr., Chairperson	University of North Carolina at Chapel Hill
Lewis, Andrea	North Carolina Division of Child Development
Britt, Holli	North Carolina Division of Child Development
Hunt, Hope	North Carolina Division of Social Services
Tanner, Tammy	North Carolina Division of Child Development
Zigmund, Donna	North Carolina Department of Health and Human Services
Tobin, Kathy	Parent Representative
Ferguson, Karen	North Carolina Division of Child Development
Hall, Terry, Facilitator	North Carolina Office of State Personnel
Jones-Wilson, Diana	Faith Partnerships, Inc.

CHILD PARENT FEEDBACK WORK GROUP

NAME	AGENCY
Hice, Mandy	Parent Representative
Ware, Joan	Wake County Smart Start
Jones, Tammy	Parent Representative
Tobin, Kathy, Chairperson	Parent Representative
Troop, Tony	North Carolina Division of Social Services
Avent-Farmer, bj	North Carolina Division of Child Development

Appendix B

CHILD PHYSICAL AND SEXUAL ABUSE WORK GROUP

NAME	AGENCY
Ware, Joan	Wake County Smart Start
Hice, Mandy	Burke County Interagency Coordinating Council
Thigpen, Fran	Buncombe County Child Care Services
Tolle Whiteside, Jennifer	Prevent Child Abuse North Carolina
Schweitzer, Michael	North Carolina Department of Juvenile Justice & Delinquency Prevention
Smith, Jean Dr., Co-chair	Child Medical Evaluation Program
White-Hearn, Rose, Co-chair	North Carolina Attorney General's Office
Jackson, Brenda	Greene County Department of Social Services
Billman, Denise	Wake County Human Services
Lankford, Gail	Wake County Human Services
Beeker, Renae L.	North Carolina Day Care Association
Deitch, Al	North Carolina Department of Administration Youth Advocacy & Involvement Office
Thomas, Melanie	North Carolina State Bureau of Investigations
Rhoney, Tammy	North Carolina Division of Child Development
Woodcock, Kathy D.	UNC-CH School of Social Work
Baker, Yvonne	North Carolina Division of Child Development
Kennedy, Jackie	North Carolina Division of Child Development
Britt, Candice	North Carolina Department of Social Services
Moore, Beverly	North Carolina Division of Child Development
Sanders, Alan , Facilitator	North Carolina Office of State Personnel
Avent-Farmer, bj	North Carolina Division of Child Development
Pugh, Lorie	North Carolina Division of Child Development
Wood, Graham	Wake County Sheriff's Office
Palombo, Frank	North Carolina Association of Chiefs of Police
Brawn, Lynne	Cary Police Department